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SOME THOUGHTS ON THE PURCHASE OF PRIVATE INSTITUTIONAL CARE BY PUBLIC AGENCIES*

Norman V. Lourie
Executive Director
Association for Jewish Children
Philadelphia, Pennsylvania

Mr. Lourie discusses the types of children for whom the public agency should purchase institutional care, and points up the public agency's responsibility to see that the child who is placed gets the service he needs.

MANY people, sometimes on a thoughtful philosophical basis, resent the intrusion of public welfare agencies into the prerogatives of the privately managed philanthropic enterprise. Setting standards for the care of children by the public bodies—licensing, inspection, planning, evaluation—are by no means universally accepted either as appropriate public duties or as necessary for safeguarding the rights of children.

In our country the development of public responsibility for children's welfare came slowly. In the 1860's the idea of government responsibility relative to private enterprises was marked by Abraham Lincoln's unforgettable words:

> "The legitimate object of government is to do for a community of people whatever they need to have done, but cannot do at all, or cannot do so well for themselves, in their several and individual capacities."

From this type of thinking our modes of partnership between private and public agencies within the ideals of democratic America have been developed.

Public Agency is Accountable to Public

The strength and value of the private agency lies in its freedom and flexibility, the public agency's strength lies in the fact that it is the agent through which the people of this country can properly exercise their full obligation to children.

Government is the only instrument through which all the people can cooperate to carry out this responsibility; only a governmental agency can be made accountable to the people for the coverage required to assure provision of whatever social services are needed by any child.

On these premises, we have come to believe that without respect to race, creed, legal or economic status, and without regard to where he lives or any other consideration except his individual needs, the public agency has responsibility to see to it that social services of every type which a child requires in his home or outside his home should be available in every locality. We have come to believe also that when these cannot be provided by private resources, the public agency must do the job directly with its own personnel and facilities.

We believe that services to children, no matter under whose auspices, must have appropriate standards which a public agency should require when it purchases institutional care. I would be remiss were I merely to set forth for you what has already been so ably said in manuals of standards worked out by public authorities and national standard-setting bodies. Many of you have undoubtedly written in such manuals and lists of standards.

The issues that seem to need emphasis are broader ones.

We believe that public funds should be spent and controlled by public agencies within the framework of the statutory existing considerations.

Then we have the principle that within the American democracy private agencies should be privately supported. And just as the public has its responsibility and accountability, the private agency should retain control and responsibility for its work.

Although some make the case that these are mutually exclusive, they do not contradict each other really and it is sound public policy to have a public welfare department purchase service from a private agency. It needs to be kept clearly in mind that the public agency has the statutory and often judicial mandate and on voluntary parental request, to take responsibility for the child, but that it may not have the services to meet the child's needs at that particular time and, therefore, the service of the private agency is purchased.

It is within our principles for a public department to pay for the total cost of a child, particularly in a special type of situation where only the flexibility and freedom of the private agency is able to develop the particular service. The point of emphasis here must be that the public agency makes the decision about the placement, knows what it is buying, evaluates what it is buying, and is involved in the setting of the standards.

* Delivered before American Public Welfare Association, Chicago, Illinois, September, 1953.

Although there are many variations within our purchase of care programs, it is well to note that within our principles even should a private agency pay completely for a service it is giving to a child, so long as that child for social or judicial reasons is a responsibility of the state, the setting of standards and the evaluation of the service, and the ability to say "yea" and "nay" as to whether the child is getting what he needs, is still a public responsibility.

Private Enterprise

We are all aware of the criticism in some circumstances that licensing, standards, evaluation, ability to make final determinations are interference in private enterprise. I would like to submit that the business of caring for the nation's children cannot be discussed in the same breath or with the same emphasis as private enterprise. It will suffice to mention how imperative our government, concerned with the common welfare, found it desirable to enter into and control some of the affairs of private enterprise in order to avoid economic and social disaster.

The private agencies cannot give all of the necessary services to children any more than the family service agencies were able to provide all of the welfare and assistance services from the 30s to today. Nor should they, under the philosophy of what private social agencies exist for, want to give all of the services. Private children's agencies were conceived within a totality of American, democratic thinking—within the thinking so ably expressed by Abraham Lincoln—so that they could use their strength, their flexibility, their freedom, their initiative, their creativity to demonstrate, to show needs and to help establish as a right for all children, those services which belong as part of the common good. We do not need to rehash the examples of the development of public education, of public health services, of Social Security. We do not need to retell the story of the Federal Children's Bureau or of the development of public welfare departments to make the point. Perhaps our best evidence is the large number of children that the public authorities seek to place in private institutions rejected because the children are too difficult for them to deal with. Similarly we can cite the large number of children originally accepted for care by the private institutions and returned to the public department because the children required service which the private agencies were unable to provide.

Challenging A "Mass" Job

In those localities where the public-private job is more properly divided and where we have had the experience of the development of public services for children, and we know that these are all too few, we have evolved the principle of the public's doing what is roughly termed the "mass" job. Usually it means long-time care for the average dependent child, for the feebleminded and the psychotic child. The private-agency in these situations theoretically does the short-time job, the more difficult type of job which requires the more intensive resources of its more flexible structure. How often is this the reverse? How often do we find the private agency doing the more comfortable job and turning back to the overburdened and underbudgeted public agency the difficult children who require the most sensitive, technical care?

We know that in some localities an undue proportion of public funds are administered by private agencies on a subsidy or purchase of care basis. Yet in some of these localities the public does not have the responsibility of standard making, licensing, or evaluation. The private agency does not have sufficient funds and is asking for more public money. The public departments have a real desire to do a more complete job but are not properly supported by the private agency community of citizens either through legislative pressure or in terms of getting sufficient budgets. And the children suffer.

Making Sound Judgments

I believe that a public welfare department having the responsibility of placing children in institutions should ask itself the following questions:

1. What different kinds of institutions do we need?
2. For how many children should each different kind of institution be planned?
3. What kind of regime or care should be planned to be provided in each institution?
4. How nearly do the existing institutions in which children are placed meet the variety of needs that an ideal set of services would provide?
5. What new or different institutions or changes in the existing institutions are required if the present available facilities are inadequate?
6. Do the available institutions to which the children are allotted meet the needs quantitatively or are there unmet needs from the point of view of numbers as well as types and quality of care given to children?

The first obvious requirement is that a public welfare department should have the facilities, including properly qualified professional staffs and small enough caseloads, to make properly the determination as to where a child should be placed, and to judge whether he is getting what is purchased. We have learned enough psychologically about the trauma of separation of children from their own

parents to have given us certain convictions. We are a society of families and we believe that short of a child's ability to remain with his own family and given a set of reality, emotional and physical circumstances, a child ought to be living in a family-type of situation wherever possible.

Secondly, institutional treatment is appropriate for certain children under special circumstances when based on sound casework judgment enhanced by such factors as parents' attitudes and feelings, psychiatric and psychological advices and knowledge of the values of the available institutional programs.

Thirdly, no child under eight years of age is generally deemed suitable for the ordinary institutional program and such placements should be avoided wherever possible.

Fourthly, a child's stay in an institution should be relatively short and every attempt should be made to return him to his family or to life in a family as soon as possible. This is, of course, excepted in certain instances requiring long-term institutional care, *i.e.* chronic, severe psychosis or unreversible, extremely low intelligence.

Children Who Need Institutional Care

Considerable thought has been given through study and evaluation of which children who need placement require institutional care. I am submitting for your consideration a listing of the type of placed children I believe require institutional care as against foster home care.

First, there is the adolescent with serious behavior problems whose behavior is dangerous to himself and others and who has or may be apprehended for legal delinquency.

Parents, teachers, social workers, discipline or indulgence have not helped him to conform. His family life is usually pathological. He is hostile, mistrustful of the adult world and everyone is his enemy. He is basically a fearful, weak child whose external behavior surrounds a well of unhappiness which often is equal to psychic illness requiring the deepest understanding, kindness, and scientific treatment within a controlled environment. These are the children who cannot use community facilities. Our training schools are crowded with such children, though to large measure lacking the proper facilities for their treatment. These children need what we have more lately called Residential Treatment. Too few such facilities are available. Our average institution is apprehensive of these children but we must change if we want to make inroads in the care of these so-called juvenile delinquents.

Second, are the severely disturbed young children and adolescents. They are not unlike the rebellious group in the etiology of their problems, but the symptomatic expressions are different. The adolescents here are the younger disturbed group grown up without having received proper care.

Some may have aggressive symptoms too, but these are not their primary trouble. They are the more bizarre types with psychosomatic complaints, school problems, inability to use their full intellectual capacity, still enuretic, often friendless, etc. These are traditionally the emotionally disturbed. Some might be termed schizophrenic, psychotic, etc., depending on what school of psychiatric diagnosis is applied. Some may be candidates, at the time they come to the institution for mental hospitals but all are potential candidates. They are children beset and upset by life and its problems. It is as natural for them to react as they do as it is for an infection to ooze pus. These are the children whose lives may be lost to society, who may become one of the twenty who get to mental hospitals unless they are given proper treatment early.

These are the children who represent discomfort for the average institution which is more comfortable with the less upset child who more rightly and more quickly ought to be returned to a family type of living. Probably for best results the older and younger children of this type ought to be separated in institutions. They are troublesome, difficult and unhappy. They represent a dishearteningly large segment of applications to private agencies who are rejected because "no service is available." They suffer from deep-seated and severe emotional difficulties. They, too, need Residential Treatment care.

I do not believe that we need to create new institutions for these two groups of children. They can be treated in institutions—if these would retool and put in the existing staff, atmosphere and program that is required, and get into foster homes, own homes and adoptive homes so many children now crowding some institutional facilities.

Third are what I would term the unadjusted children from problem families who probably represent the largest number of children requiring institutional care.

These are the children from often unhappy, neglectful homes whose poor adjustment is temporary. They lack serenity, security and affection. Separation is important for them but immediate foster home care has been found unworkable, and unsuitable for the time being.

These are children who could become seriously disturbed or aggressively antisocial if they are not helped to relate to adults, to feel safe with themselves, to pull themselves together, as it were.

They can be put together relatively quickly and should be in small groups, in family-like institutions

for relatively short periods of time and should be placed in family living as soon as they are able to accept a family. They need casework help and sympathetic, skillful adults around them. They should not be removed from normal community living.

Fourth are the adolescents who are attending school or working on their first jobs for whom foster home living is unsuitable. Their own families are temporarily unable to accept them or may never be ready to do so. There is no point in returning them to the tensions and difficulties which caused separation from their own families in the first instance even if they have outgrown foster home living for any reason.

For these children the small group home or residence club is ideal.

In this group there may even be children who have come out of institutions for the groups mentioned previously. They are children who have reached the age and situation where under proper adult guidance, living in a normal community setting, they are ready to take the final step toward independence or toward ultimate reunion with their own families.

Fifth, are the children with serious physical handicaps. These, when requiring placement away from home, may require it for reasons of the physical ailment alone or they may have personality traits in addition which correspond to the other groups mentioned.

In this group there are children whom we can classify in the category of unmet needs—the spastic, paralytic, etc. For these groups there is need for experimentation and private agencies need to be stimulated to try new approaches. Public facilities, too, are limited. These are the children who elicited sympathy but relatively little institutional action over the years perhaps partly because they are more difficult to take care of and the results may be considered as less rewarding than in bringing up the traditional pink-cheeked, blue-eyed children. I believe that some experimentation in caring for these children in foster homes should also receive attention.

The sixth is a disadvantaged group and the children's agency flag of "no service available" is up for them—the unadjusted, mentally retarded children.

Public agencies are backed up with these children. Traditionally they are a public responsibility and the waiting lists in public institutions are long. Public Welfare Departments are besieged by families whose lives are disrupted and frustrated by the presence of a child about whom they feel completely helpless. Many have been in foster homes and institutions but because proper educational care and facilities are lacking they are declared unsuitable for such placements. For this group much remains to be done by the private agency and experimentation should definitely be encouraged. We have learned too often and too bitterly how many might be saved to become productive citizens if enough is put into their early training. Experimentation by private agencies with small institutional groups which would avoid the competition of numbers and allow for concentrated educational effort might eventually prove that we could save millions of public dollars in long-time care with adequate service and appropriate timing.

The seventh or last group might be broadly termed the children needing temporary shelter. This might be for protective reasons following emergent placements while determination is made regarding disposition or because a child who we know will eventually go into a foster home is for good reasons, temporarily unsuited for a home placement.

I avoid trapping myself into the controversy about the type of care "most suitable" for protective services. I do say that we should continue the trend toward using foster homes in these situations whenever possible, particularly for young children. Understandably, each community needs some form of emergent shelter, but when the shelter becomes a long-term institution, as many are, we are putting children at a disadvantage.

I have not offered specific measures by which you might evaluate a service which you purchase. Rather I have tried to outline for what kinds of children the public ought to be purchasing institutional service. Clarity on this point plus carrying into practice sound principles of public-private relationship will produce the most effective safeguards for children whom the public department places into private agencies.

Standard-Setting, A Public Responsibility

A public agency has the responsibility for establishing acceptable standards for children's services. We have seen that the problems of children who need institutional care require the highest professional skills and varied facilities of good standards if they are to be able to grow properly. It is likewise a public department responsibility to supervise and evaluate the private agencies within these standards and to be the final authority on intake and disposition of children. I repeat, these functions must be performed within a framework of acceptable professional standards. In a sense the private institutions should be led and stimulated by the professional quality of the public service. It is my conviction that private agencies will become more effective as the public agency becomes more effective though the opposite point of view is often expressed. On the other hand, private agencies have the responsibility to accept the standards set by the public and to go beyond, but

never below them. They should not be allowed to reduce or dilute these standards in order to provide coverage in the field of statutory responsibility. When more and different service is needed, the public agency has a choice, it can encourage private agencies—within the limits of the standards—to expand, to contract, to change their functions, to meet needs and to experiment in uncharted areas. When the private institutions cannot meet the challenge, it is the time when the public department must talk about setting up public facilities. Here the private agencies' role should be that of the responsible, effective unselfish citizen—to support the need rather than to beg the question within a limited interest.

We shall be carrying out our obligations to children if, in the long run we can continue to keep our sights on the thought that certain child-care services are both a basic need and an inherent right of each individual child and that the American democratic ideals of providing for the common good and constantly enlarging the mode of the general welfare should be the measures for our practice.

I BELIEVE IN PARENTS*

Esther Schour
Executive Secretary
Child Care Program
Institute for Psychoanalysis
Chicago, Illinois

Mrs. Schour points up the need for social workers to reevaluate their attitudes toward the parents of children in trouble.

IT was on the occasion of Thoreau's graduation from Harvard. Emerson congratulated him. "You should feel proud," he said. "It's a wonderful school. It teaches all branches of knowledge." Thoreau replied sadly, "That's the trouble; it teaches all branches of knowledge but not the roots."

Believing as I do that the child's development is rooted in his feeling about his parents, I feel impelled to talk about children's parents—and our attitudes toward them.

It is hard to be a comfortable, confident parent today. There is a tendency in our society and on the part of professional people dealing with children, to blame parents, particularly mothers, for all the problems, behavior disorders, and neurotic symptoms of their children. It is as though we regard parents as an affliction from which children suffer.

The catch statement, "There are no problem children; only problem parents" has taken hold too widely and too literally. How did this come about?

Emphasis Has Shifted Over the Years

Until about fifty years ago, the child's problems were attributed to heredity and constitution. The child was born good or bad. Parents were fortunate to have good children; they were objects of pity if their child was bad. This explanation of the cause of the child's maladjustment was relatively easy for the parents; parental guilt was minimal. Perhaps it was easier for social workers too. If maladjustment was due to heredity, its treatability was limited; hence, our adequacy and skills were less threatened.

Then about twenty-five years ago, there was a swing to the other extreme. Environment came to be regarded as the most powerful force in shaping personality. Since parents constitute the child's earliest environment, they were held responsible for the kind of child they brought up. Out of our greater understanding of the importance of the early mother-child relationship for the development of the basic qualities of confidence and trust in the child, mothers especially began to be blamed for whatever went wrong. Today we know that the factors responsible for children's maladjustment are multiple and interwoven. Both constitution and environment play their roles and in the environment, parents are vital factors in the child's development, but they are not the *only* factors. Current psychoanalytic psychology teaches that individual personality is the product of constitution, early experiences in the family, of which parent-child relationships are most significant, and later life events. It is an oversimplification, and actually not true, that all children's problems result from disturbances in the parent-child relationship. Constitutional factors, such as the child's physical and intellectual endowment, contribute positively or negatively to his ability to master his environment. We know that children very early in life must learn to deal with their own drives which differ in strength,

* Delivered at South Pacific Regional Conference, Santa Monica, California, March, 1954.

with their relationships, first to parents, and then to other people in their environment, and with life events. At each level of development, the child is confronted with characteristic problems which he must learn to solve. Parents, of course play a significant part in helping the child to cope with these problems, but the child's innate potentialities also influence his solution. A child's maladjustment may result from his own inability to satisfy his inner needs because these needs are so strong. It may also result from his inability to accomplish the developmental tasks required at different age levels, because he is ill equipped to do so. Accidental life events, too, such as bodily injury, death of the parent or a sibling, can be traumatic for the child's development. Unwholesome relationships with peers, with teachers, with others outside the family, create problems in the child's adjustment despite good parent-child relationships.

Our frustration in dealing with the many complex factors underlying maladjustment is great. While intellectually we accept that children's problems have multiple causes, emotionally, we still tend to look for a single factor on which to focus blame.

It is understandable that child welfare workers working with children severely damaged should feel empathy with them. It is difficult to understand and deal with parental attitudes and behavior that are injurious to the child's development and to his treatment. These are realistic factors that may rouse our anger and negative feelings toward parents. However, it is also true that many of us have unresolved problems in relation to our own parents and because of these, we may tend to identify with the child client, and to depreciate, ignore, and blame his parents. In so doing, we take on the attitudes of the lay community to parents and become less professional in our approach to them. We may make an a priori judgment "that the parents aren't much good, if the child is in trouble." This prejudgment is accompanied by our failure to look for strengths in parents and failure to utilize such strengths for the treatment of the family and the child.

Parent and Child Have Reciprocal Relationship

Many factors disturb healthy parent-child relationships. It is almost axiomatic that the parents' own personality and attitudes and behavior are overwhelmingly powerful in influencing their relationship to the child. But we have also to be aware that the child's behavior and personality, in turn, influence the parents' reaction. Dr. Therese Benedek has stressed the mutuality of parent-child relationships. The mother's response to her baby is motivated not only by her motherliness, her own capacity to love and protect a baby, but by the kind of baby she has. A baby who is irritable, restless, has nursing difficulties, may be very frustrating to the mother who wants to nurse, give comfort and satisfaction to her baby. Her frustration and anxiety then is communicated to the child, who may respond with more irritability. This can begin a mutually unsatisfactory relationship. Or a phlegmatic baby whose normal growth is slow, may thwart the mother who is active and energetic. Children differ at birth, in their reactions and in the tempo of their development. The baby's behavior influences the parent's reaction, just as the parent's handling can modify the direction of the baby's innate tendencies. This mutual, reciprocal influence extends throughout childhood. As the child grows, his own unique patterns of behavior which he uses to get what he needs, provoke counter-reactions in the parent's feeling toward him. Often the child, as well as his parents, needs help in modifying his behavior.

Current and immediate problems affect the parent-child relationship. Lack of satisfaction and conflict in marriage, divorce, separation, or death of one parent, modifies and upsets the existing relationship between the remaining parent and his child. Problems in day-by-day living leave their mark on this relationship, too. It is harder to be patient, understanding and giving to children, to express what the Fact-Finding Report of the Midcentury White House Conference calls the "parental sense" when parents must struggle with economic problems, inadequate income, periodic unemployment, poor housing, poor health, and limited opportunities for the satisfaction of their needs as people. These can jeopardize the parents' relationship to their child even when parents are relatively mature. And often it is only one parent doing the job of two who must cope with these problems.

The confusion in child-rearing practices in the past twenty-five years has also contributed to insecurity in parents' relationships with children. In this period, we moved away from the belief that the child should be seen and not heard—often to the other extreme. The child whom we recognized as an individual in his own right, became the hub around which the family revolved. In this period, the pattern of infant feeding shifted from observance of a rigid schedule, to the self-demand schedule; from early toilet training, to great laxity in toilet training; from the strict control of aggression in children to absence of all control. There is indication of a new shift—from child centeredness to family centeredness with freedom for the child, but with some limitations. We have moved from exalting the child's right to self-

determination to a point of understanding that parental protection is the parent's responsibility and one of the child's basic needs. These changes have been confusing to parents and children, and to professional people working with them.

Parent's Personality is Important Factor

A vital factor that influences the parent's relationship to his child is his own personality structure. Our own experience as social workers bears out that the child who finds love and security in his own family has a better chance of growing up into a healthy, responsible adult than the child in whose family these qualities are lacking. Feelings of love, security, self-esteem and adequacy do not spring into being in a vacuum. They are nurtured by two ingredients:

1. Concrete and tangible material supplies, *e.g.*, living at home in a family setting that provides adequate food, decent housing and clothing that do not set the child apart from others in his neighborhood. It is the satisfaction of physical needs which in early life nourish not only the body, but the child's sense of well-being, safety and fulfillment, and which spell love and security.
2. The supporting affection, protection and reliability of parents who can meet their children's dependent needs, help them reach out for new experiences and guide them gradually toward independence. This in turn enables children to marry, to become parents, to establish their own families and become participating and responsible members of society.

In our work we often see parents who are immature, who have not developed "the parental sense," or developed it inadequately. Many of our clients are parents, who as children were unloved, uncared for, unprotected and deprived materially as well as emotionally. All parents bring to parenthood unconscious attitudes and feelings, and patterns of behavior that grow out of their own childhood relationships and cumulative experiences with their parents, siblings, and other people in their environment. When these are distorted, the parent's attitudes toward his own child are often disturbed. For instance, a parent who has failed to accept his own sexual role, who has not resolved his feelings of competition and rivalry with his own parents and siblings, who has need to realize his own ambitions through his child, who sees his child as an extension of himself rather than as a separate individual, is apt to displace on the child his own conflicts, confusion, and ambivalence, and these contribute to the problems of the child.

Own Family is Basic

Child welfare begins in the child's own family. Out of our conviction that the child's own home is in general the most satisfying and constructive environment for the physical and emotional development of children, we must make it possible early for parents and children to get adequate help in adjusting to each other. Material and psychological help must be provided to further the child's adjustment in his own home. This is the basic approach to child welfare.

Out of the community's intuitive recognition of the importance of preserving the family, and the family's need for help to remain together, was born the private family agency, one of the earliest philanthropic efforts of the community. The A.D.C. program evolved because the public recognized that government had a responsibility for safeguarding family life threatened by dissolution. Added knowledge has shed new light on the needs of children for their own parents; on the needs of very young children for the mother's presence and care; and on the increased urgency of that need in the absence of father, when the family as a unit is already weakened. If we have conviction about this we should not press mothers of very young children to go to work, when for any reason the father is absent from the home. We should, on the contrary, provide budgets that permit the maintenance of a decent, healthful standard of living. We should encourage and help the mother in her efforts to unify and stabilize the remaining family. This is the mother's job. It is shortsighted to expect the mother to leave this job for one that brings monetary income now, but jeopardizes the child's development into a responsible adult.

But not all mothers are equally equipped to care for their children. There are mothers who want to and need to work. The mother's employment in such cases may be a constructive experience for the family, provided adequate plans are made for the child. We need, therefore, to develop good day care facilities and also adequate provision for the care of the children living at home while the mother works.

Ties Remain Despite Deficiencies

There are children who are physically neglected, whose relationships are completely destructive and these form obstacles to their developing into responsible adults. These are the children whose parents are not only uninterested, but actually uneducable. In these, there may be no constructive values for the child in the family, and placement may be indicated. But even in such situations, we know that placement does not sever the mutual needs and influence of most parents and children on each other. Except in unusual cases, parents do not totally relinquish their child, nor does the child sever his ties to the parents. Even parents who appear hostile and rejecting, un-

able to provide care and guidance, have some positive feelings for the child. Similarly, we know that deprived children, struggling for a sense of self-value and identity, cling to their parents for the small love and security they have found. Furthermore, parental attitudes and values have become part of the child's own character. They continue to exert influence from within the child and the parent, himself, continues to exert influence from without. So, in our work, we cannot ignore the parent, even those who have very little to offer. We have to involve him in planning with us. Our aims in working with such parents may be limited. But whatever the aim, our attitude must be sympathetic and understanding. Our relationship to parents should mirror a positive parent-child relationship. It is true that many can use only minimal help. However, we should not prejudge this. Our over-all attitudes and our negative appraisal of their capacity to use our help influences how we offer it, and their response to it. Out of our antagonism and depreciation, we often conclude pessimistically, and without careful diagnostic basis that they cannot change anyway. Some parents cannot change. Many can and do. Sometimes we grant that if they can, any change that they will make can only be a small one. But we have to reaffirm what we have learned from our experience and from dynamic psychology—that small changes in parental attitudes and behavior can materially improve the child's adjustment.

Like Thoreau, we must be concerned with roots. This, in child welfare means concern with parents. We should keep in mind that parents too, were once children, who were failed in their early relationships and life experiences, and who did not have subsequent corrective experiences. Blame is not a helpful attitude. As social workers, we must, in each case, out of our knowledge of the conflicting forces that shape us, work with compassion and skill in support of whatever measure of adequacy parents may have, in the interest of both parents and children. This is basic to any approach to problems of child welfare.

Anna Freud to Speak at National Conference

AT the League's Annual Dinner Meeting on May 13, Miss Anna Freud, eminent child psychologist of London, England, will speak on the subject, "Protecting the Emotional Health of Our Children." She has chosen this topic because of the recent attention now being paid to the events of the infant's first year of life and his reactions both to the satisfactions and frustrations provided him by his mother. She emphasizes that where the mother succeeds in establishing good relations with her infant, she safeguards his emotional future; where she fails to do so, she damages his growing interests and contacts and endangers his ability to form stable and lasting emotional relationships. This "rejection" of the infant by the mother has become the urgent concern of many workers, who believe that our growing understanding of the earliest mother-child relationship will create new opportunities for helpful intervention, and thereby protect the emotional health of children at the beginning of life. In her address, Miss Freud proposes to examine critically this concept of "rejection" and to discuss in detail the meaning of this particular maternal attitude from the infant's point of view and also the mother's.

Anna Freud is currently with the Hampstead Nurseries, located just outside London. During the war, Miss Freud and Mrs. Dorothy Burlingham, an American Psychologist, directed three wartime nurseries in London under the auspices of the Foster Parent's Plan for War Children. The results of their work were published in 1943 and 1944 in two books, *War and Children* and *Infants Without Families*.

CONFERENCE CALENDAR—1954

(* Note Revised Dates)

National Conference of Social Work
* May 9–14
Atlantic City, N. J.
League Headquarters: Hotel Ambassador
League Program Committee Chairman:
Miss Daisy S. Young, *Chief*
Bureau of Children's Services
Department of Welfare and Institutions
Richmond, Va.

Subcommittee Chairmen:
West Coast: Mr. Stuart R. Stimmel
Portland, Oregon
Midwest: Mrs. Mary Lawrence
Chicago, Illinois
East Coast: Mr. Norman V. Lourie
Philadelphia, Pennsylvania

New England Regional
May 24, 25
Wentworth-by-the-Sea, New Hampshire
Chairman: Linwood L. Brown, *Executive Director*
Sweetser Children's Home
Saco, Maine

A BOARD MEMBER SPEAKS

An Agency Reviews Medical Care For Children

THE Case Committee of the Family and Children's Society, of Montclair, recently reviewed the existing methods of medical care for its clients, evaluating them and, after due consideration, recommended changes in the program to include broadening the medical supervision and care of our infants and children, especially those in foster family care.

It was an enlightening and stimulating series of meetings for the six lay members of the Board to meet with an outstanding pediatrician and three other professional members of the Committee, the Executive Secretary, Case Supervisor, and a caseworker. We heard their views on current procedure and the difficulties and drawbacks it presented, and discussed the possibilities for immediate and long-term change. Simultaneous with the meetings of the Case Committee, staff discussions were being held on the same subject. The caseworker sitting on the Case Committee acted as liaison between the two groups.

Board Recognizes Inadequacies

We realized at the outset that the Staff and Board were fortunate to have the keen interest and advice of one of the community's foremost pediatricians, not only on the Board, where he served in an advisory manner, but to work actively with the agency when medical emergencies arose. However, it was soon apparent that too many problems had been laid in this one doctor's lap to be solved quickly; and frequently emergencies had arisen which could have been avoided by a more adequate preventive medical care program.

We had used the well-baby clinics, generally with successful results, but the difficulties of some of our babies, shown through lack of proper development, or alarming dietary troubles, gave every reason to question the adequacy of such care. Even in cases where the family doctors of foster families had been used in outlying communities, it was found that serious illness of babies had occurred and it was felt that proper diagnosis and treatment could have prevented some of this. The Committee was amazed that our staff had managed so well to keep these cases down to a minimum, and that whenever necessary, they had been able to call on the pediatrician on the Board. It was felt, however, that the children needed better protection and that it was asking too much of the workers as well as the doctors connected with the Society, to take a responsibility that should be assumed through an adequate agency program of physical examination and supervision before and during placement in foster families. The Board could also see that many hours of the caseworker's time were being consumed with waiting in well-baby clinics—time that was so badly needed in other directions. Actually, it could be called a most wasteful and expensive form of baby-sitting

We came later to realize that many difficult family counseling cases also held medical connotations that only a physician could accurately interpret. Again we marveled that our staff, when confronted with medical reports of specialists in various fields which were necessarily written with a highly technical vocabulary, had managed so well without the immediate aid of a medical consultant.

It was clear to the Case Committee that a very able staff was being hampered both in time and working procedure, by a program of inadequate medical consultation and supervision, and also that too many expensive hours were being used in transporting sick babies and responding to emergencies.

Our immediate concern was to recommend to the Board specific necessities for a better medical program for babies and children, to go into effect as fast as possible. We also planned to work out a program with specialized consultants for other types of service for example, expert consultation on infertility in behalf of adoptive applicants as might be necessary. Much time and effort and pooling of ideas and opinions went into making our final decisions.

Five-Point Program Proposed

The result was a five-point program considered necessary to provide adequate care for the babies and older children. First, we recommended that there be a pediatrician as consultant to advise on the entire program, to give the program "continuity and a better quality of service throughout." Second, that all children receive initial examinations and evaluation by a pediatrician, either the consultant or someone to whom he delegated this responsibility; a process that must include in addition to thorough physical

examination, obtaining background history and all necessary laboratory work. Reports of this examination on any child were to be available at any time. Third, that periodic follow-up examinations be given by neighborhood doctors on a paid basis, the consultant to assist the agency in selecting a physician within a reasonable distance of the foster home to follow up each child. The child's caseworker would accompany the child for re-examinations, and would interpret the agency's general program as well as specific procedures to the physician giving the follow-up care. It should be stated here that the foster mother or some other member of the foster family to whom the child feels close, also may accompany him. The consultant would continue to assume responsibility for medical supervision, discussing the child with the follow-up doctor from time to time. Fourth, if a child required hospitalization, he would be under the consultant's care during this time. Fifth and last, thorough pediatric examinations would be given prior to discharge and would be made by the consultant or by a pediatrician designated by him. This measure was considered particularly important in cases of adoption as a safeguard not only for the child but also for adoptive parents and the agency.

In discussing the matter of probable increase in costs, the Case Committee was emphatic in its feeling that even a substantial increase in the cost of care was not so important as the health of the children and that the "establishment of a sound medical program would be an important step toward meeting the agency's commitments to work for development of healthy, happy and useful citizens." It was also emphasized in feeling that the valuable time of staff members had been expended in costs which were hidden and until now, not recognized.

In discussion of plans and purposes of our children's medical program for the present and the future, the whole committee gained perception in relation to the agency service. We also gained more understanding of the joint responsibility of the staff and the Committee toward these important members of our community—the children dependent on us for care. We are definitely convinced that there is constant need for such mutual discussions to see more clearly how the joint abilities of lay and professional members can best find their place on such a Board.

It was a most stimulating and satisfying experience and will, we hope, lead to further medical and staff cooperation in more diverse fields in the future.

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NEWS FROM THE FIELD

The Physician's Role in Adoptions

Editor's Note: *We are pleased to have permission to publish the following which appeared in the editorial columns of the* Journal of the Kansas Medical Society*. *We see two valuable ideas in the statement of Dr. Geoffrey Martin, Director of the State Board's Division of Maternal and Child Health, who describes the editorial as "a spontaneous expression of sympathetic interest from one profession to another, arising from a meeting in which plenty of time was allowed to discuss the problem, and is in a sense the beginning of a campaign of public and professional education." We want to call particular attention to the last paragraph which pleads for more interprofessional cooperation.*

RECENTLY the Committee on Maternal Welfare met with representatives of various private and public child placement agencies in an effort to become more familiar with their problems. Obviously, these agencies have many activities of no immediate concern to this committee, but it was felt that certain points of discussion regarding the placement of newborn babies warranted more general dissemination.

Any physician who performs deliveries is certain to be approached sooner or later by some couple hoping to gain his co-operation in obtaining a baby for adoption. The agencies have long felt that the physician who assumed such an obligation was unwise, if not actually performing an illegal act, in so doing. The committee attempted to balance the factors on both sides and arrive at some recommendations.

Without doubt, the peculiar and apparently insoluble core of the problem is the great disparity between demand and supply, currently estimated at about ten to one. So long as the reproductive process continues at its present long and somewhat haphazard course, there can never be enough children unwanted by their natural parents to gratify the desires of prospective adoptive parents. Immediately, then, the available supply is subjected to the same pressures as any other scarce commodity in the market place. This very situation produces many of the criticisms leveled at placement agencies and should warn physicians not to consider themselves omniscient where passing out babies is concerned. In couples seeking children, it is this shortage which brings about the frustrations and antagonisms they direct toward the agencies. So, they contact the physician with complaints of delay, procrastination, and "unnecessary" investigations. They present a strongly emotional case for by-passing such "red tape" and

* *Journal of the Kansas Medical Society*, Topeka, Kansas, September, 1953, p. 423–424.

precipitate a conflict between the physician and the agencies, where there should be mutual assistance and co-operation. It is this great demand which prompts the agencies to adopt a policy of caution and exhaustive investigation before placing a child.

The complaint that a long period of time elapses between application and placement should be no complaint, according to the agencies, because it is a means of protecting the prospective parents and the child as well, a precaution Mother Nature does not always take. The adoptive home is studied in all of its aspects. Adequate background information is obtained on the natural parents, which is of value in the prognosis of the infant. Only rarely, if ever, will the individual physician be in a position to determine all aspects of the situation as well as the agency can.

The objection is raised, then, that natural parents take their chances, and certainly the offspring has nothing to say about his natural parents. Why must adoptive parents and babies be surrounded by this "unnatural" exploration and study when they, the former at least, would be willing to assume a certain risk in the results? Such are the ways of life, say the agencies, and they are the first to point out that adoption is an unnatural process which should be strictly and cautiously executed. So long as the responsibility is theirs, it is only wise that they respect that responsibility to the greatest degree, not disregard it for some expedient based on emotion or financial remuneration.

Placement agencies, by covering a wide territory, can avoid one common source of trouble, the placement of a baby in the same community as the natural parents. The objection to this situation is obvious, yet this frequently results when the physician places a child directly. No mother can sign her child over to adoptive parents legally without their names appearing on the release, and, unless the procedure is pursued illegally, she then knows where her baby is going. In agency transactions, the baby is assigned to the agency, keeping the personalities completely apart. The agency's investigation insures that both natural parents give complete and legal permission for the adoption and, further, that both adoptive parents are wholeheartedly in accord with the plan and are not likely to change their minds.

A physician can usually offer the natural mother one advantage which the various agencies cannot. Through him, the adoptive parents are glad to defray part or all of the hospital and professional charges. No agency is sufficiently well off at the moment to meet this challenge. This, however, is the point of maximum vulnerability for the physician since such a practice, however innocent and legitimate, inspires lurid "black market" charges in the Sunday supplement.

The physician is motivated primarily by his desire to be of assistance, either to the mother or to the adoptive parents, or to both. If he could offer the same assurance of control and eventual success in all areas of the procedure as the agencies can, there could be no objection to his activities. Insofar as he cannot offer that assurance, he fails to fulfill the responsibility he has assumed and invites grief and dissension where he intended to bring happiness and harmony.

Locally, at least, the agencies have admittedly failed in one phase of their endeavor. That is in acquainting physicians with their methods, standards, and procedures and thus encouraging the co-operation of the medical profession. The committee, therefore, decided to take this means of presenting these points which the average physician may have overlooked. It has urged the agencies to keep the profession better informed of their assistance and services to the mother, the child, the adoptive parents, and the physician. Those physicians who may meet such problems are similarly urged to watch for and give adequate attention to any information releases originating from these agencies.

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Wisconsin Substantially Decreases Independent Adoptions

Editor's Note: *In looking at the figures on adoption recently, we were struck by the statement that in Wisconsin, 78 per cent of adoption placements during 1951 were carried out by agencies and that this was increased to 84 per cent in 1952. This was in marked contrast to figures available for the country as a whole; e.g., 55 per cent of all placements were made independently. We wrote to Mr. Fred Delli-Quadri, Director, Division for Children and Youth of the State Department of Public Welfare to ask the reasons for this difference. We think his answer is of great interest to every child welfare agency, whether or not adoption services are part of its program, as it indicates the emphasis that has been placed not only on revising actual practice affecting services other than adoption, but also on developing new and effective means of interpretation.*

IN explanation, undoubtedly, a number of factors influence this situation. Our statute does prohibit placement by any but parent, guardian or licensed agency.

"No person, other than the parent or legal guardian, and no firm, association or corporation, and no private institution shall place, assist, or arrange for the placement of any child in the control and care of any person, with or without contract or agreement, or place such child for adoption, other than a licensed child welfare agency." (Stats. 48.37 (1)).

The statutes also specifically provide for adoptive placement by Milwaukee Department of Public Welfare and the State Department of Public Welfare.

The statutes also provide a penalty:

"Any person who shall act as a child welfare agency without a license as provided in this chapter or who shall violate any of the provisions of the statutes relating to the organization, conduct and operation of child welfare agencies, or who in any way, directly or indirectly, offers to place or dispose of any child or hold himself out as being able to place or dispose of children in any manner whatsoever, shall upon conviction thereof be punished by a fine of not less than $10 nor more than $500 or by imprisonment in a county jail for not more than one year, and said term of imprisonment in case of an association or a corporation may be imposed upon its officers who participated in said violation." (Stats. 48.41 (1)).

However, we do not believe that this statute alone could be credited with the low percentage of independent placements. Some related laws and practices have had considerable effect:

1. "[The Department shall]

"(a) Promote the enforcement of laws for the protection of mentally deficient, illegitimate, dependent, neglected and delinquent children; and to this end cooperate with juvenile courts and licensed child welfare agencies and institutions (public and private) and take the initiative in all matters involving interests of such children where adequate provision therefor has not already been made.

"(b) When notified of the birth or expected birth of an illegitimate child, see to it (through advice and assistance to the mother or independently) that the interests of the child are safeguarded, that steps are taken to establish its paternity and that there is secured for the child (as near as possible) the care, support and education that would be given if legitimate." (46.03 (7) (a) (b)).

Since the Children's Code, of which this was a part, was passed in 1929, the field workers (now district workers of State Department of Public Welfare) have been expected to and have considered part of their responsibility as contacting individuals who are interested directly or indirectly in specific cases of independent placement in order to discuss the pros and cons of such procedure. From the beginning, too, the private agencies as our representatives were expected to do the same. Although the percentage has been small, such efforts have resulted in change of plan in some cases. Obviously the interpretation of the statute and the reasons why it is a protective measure are even more important.

In addition, when the facts disclose an individual, particularly a minister, doctor or lawyer, has been involved in an independent placement, a letter may be sent to him explaining the responsibility of the State, quoting the statute and offering an opportunity to discuss this.

2. "No license for a maternity hospital shall be renewed unless the person licensed to conduct the same shall have faithfully observed all of the provisions of Sections 48.43 to 48.46 and the rules and regulations of the State Board of Health issued thereunder. Before renewing any such license, the State Board of Health shall secure from the State Department of Public Welfare a certification that the licensee has complied with all the requirements of Sections 48.44 to 48.46. (Stats. 48.43 (4)).

". . . the members and authorized agents of the State Department of Public Welfare shall have access to such records as maternity hospitals are required to maintain under this section, and they shall be furnished with any information which they may require and which is in possession of such hospital or the persons conducting the same and which is in relation to the welfare of the children of unmarried mothers." (48.44 (1)).

"No person connected with the maternity hospital shall directly or indirectly disclose the contents of its records as such, except in a judicial proceeding where the same is material or where the information of the State Board of Health, the State Department of Public Welfare, or the local health officer." (Stats. 48.44 (4)).

"(a) No person conducting or in any way connected with the conduct of any maternity hospital shall in any way directly or indirectly offer to dispose of any child or hold himself out as being able to dispose of children in any manner." (48.45 (1)).

"(b) Whenever any woman is received in a maternity hospital because of pregnancy or in childbirth or within two weeks after childbirth, such hospital shall use due diligence to ascertain whether such patient is married; and, if there is reason to believe that her child is or will be when born an illegitimate child, such hospital shall report to the State Department of Public Welfare within twenty-four hours the presence of such woman." (48.45 (2)).

These sections taken in connection with 46.03 (b) have resulted in the practice of having the district workers visit maternity hospitals annually, examine the records, discuss its problems or apparent violations, etc. We believe that hospital authorities are very much aware of their responsibility and in many situations are good interpreters.

We have also had excellent cooperation with the State Medical Association. An announcement was composed jointly by their child welfare committee and representatives from the Division for Children and Youth. It was inserted first in the 1951 annual issue of their magazine which contains other resource material. This has been re-issued in the same way in 1954. During the last few years, the State Medical Society has offered to have their Grievance Committee consider any situation in which we can present facts showing a physician has acted contrary to the statutes. The committee has taken this responsibility very seriously and we believe their consideration of such cases has had considerable weight.

BOOK NOTES

Joint UN/WHO Meeting of Experts on the Mental-Health Aspects of Adoptions: Final Report. World Health Organization Technical Report Series, No. 70. September, 1953. 20 pp. (Available through Columbia University Press, N. Y. 15 cents.)

Study on Adoption of Children, United Nations, Department of Social Affairs, New York, 1953. 104 pp. Price 75 cents.

Perhaps the most significant thing about these reports, which should be considered together since they complement each other, is that they show concern about adoption in many different countries and readiness of those responsible for adoptions to exchange information and ideas. This is the beginning in an over-all interest in adoption. Adoption is no longer solely a domestic problem of any one country but cuts across national boundaries.

The "United Nations Report" based its findings to a large extent on answers to questionnaires on adoption practices submitted by agencies from a widely distributed sampling of western countries. Among the countries included were Denmark, France, Greece, Switzerland, United Kingdom of Great Britain and Northern Ireland, Union of the Soviet Socialist Republics, Yugoslavia, three Provinces of Canada, four states of the United States and five countries of Latin America. "The World Health Publication" summarized views of an international group of experts from the United Kingdom of Great Britain and Northern Ireland, the United States, Denmark, and France, together with the Secretariat of the World Health Organization and the United Nations. While the groups participating in the preparation of the reports came from countries having similar patterns of family life they represented a wide variety of social service practices, child welfare resources, and legal systems. Great credit is due to the leaders responsible for each of the reports, for the clear presentation of facts, general basic policies and prevalent opinions.

The "United Nations Report" begins with a brief presentation of the history of adoption and general comments on trends. This is followed by a chapter on "General Considerations" which points up the major topics of concern in adoption, such as the agencies' responsibilities and organization; the adopting parents and the essentials in the study of the adopting parents; the child to be adopted and the kinds of care and considerations given him to help in bringing about good placements; the follow-up of placement and the responsibilities connected with the legal aspects of final adoption. The chapter also touches briefly on worker training, research and public interpretation. Throughout, the statements are documented with references to succeeding chapters in which the topics are elaborated with examples of the adoption practices and laws of the various countries which participated in presenting information. Sections dealing with over-all and administrative aspects of adoption, such as private placements, fees, transfer of guardianship, and the effects and results of adoptions are also included. Obviously it was not possible to give an inclusive accounting of each of the countries, yet, the writers of this report showed excellent skill in selecting examples of the different ways in which countries work and in formulating general observations from what must have been a mass of detailed and subjective material. The report does more than list the findings as given on the questionnaires. The discerning and orderly presentation of the major aspects of adoption work and its wider implications could not have been achieved without careful study and analysis of all the material available.

Mental Health Aspects of Adoption is one of the World Health Organizations Technical Report Series and represents the thinking of a group of experts who met in September, 1952. While it is stated that the material does not necessarily represent the decisions or the stated policy of the World Health Organization, attention is called to the fact that wide circulation of the report has been encouraged by this agency. The discussion includes the nature and purpose of adoptions in general, and covers such specific aspects as the quality of parental feeling in the adopting parents and the quality of their marital relationships as factors affecting the child's relationship with his adopting parents. The problems of the natural mother receive consideration too; for example:

"unmarried mothers tend, in the main to be in great need of properly qualified help in arriving at an early decision about the retention or relinquishment of the baby and it is, therefore, of the greatest importance that careful study should be made of the attitude of the workers involved so as to ensure that help of the most skilful kind is available to the mothers."

Considerations relevant to the assessment of the child and the time of his placement are discussed with sympathetic understanding of all the people involved. The report ends with the presentation of thirteen broad conclusions which point up essentials in a good adoption work, a few of which warrant quoting here:

"Adoption should have as its main object the well-being of the child.

"A mere material assessment of the prospective home should be replaced by an evaluation of the whole situation.

"It is no amateur matter to decide which parents and home will fit each child, and no child should be placed haphazardly with any adopting parents.

"Among the matters needing further research are the improvement of methods of prediction and other methods of diminishing risk; the study of differences of development as between adopted and other children; and the skills involved in carrying out adoption procedures."

This report deals primarily with the human relationships of those concerned in adoption, a phase of adoption which in a large measure is the key to the success or failure of individual adoptions irrespective of when or where the adoption takes place. Each report in its own way makes a contribution to better knowledge about child adoption and its relation to child and family well-being and to community planning. But over and beyond this, each is a heartening indication of new steps in the development of greater understanding between different countries as they work together on similar problems.

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Mental Health Implications in Civilian Emergencies, prepared by the Subcommittee on Civil Defense, Community Services Committee, National Advisory Mental Health Council. U. S. Public Health Service, Washington, D.C., 1953.

This is a brief summation of pertinent questions and problems on the mental health implications of civilian defense; it is also a sound and thoughtful plea for greater appreciation of the mental health implications of any national emergency, be it atomic attack or something else. It is heavily documented throughout with the literature on the psychological aspects of civilian defense on the federal, state and local levels.

Only a confused, mixed-up world could produce so valuable, and so confusing, a report as this. The confusion comes around the basic question: how to keep a civilian population psychologically prepared for surprise attacks and national emergencies which may never happen. Throughout the report there is a tendency to view with alarm the assumption that the public is apathetic about civilian defense and refuses to face the dangers all about us. Just as we are about to get a rounded statement of this point of view, we are then reminded that it is not really possible anyway to keep people prepared psychologically for an atomic attack. In other words, we cannot expect people to maintain a high level of emotional readiness for atomic attack over an indefinite period of time; and, even if we could do this, the effect might be about as destructive in subtle ways as an actual attack.

Then the authors present us with the sensible point of view that the only way really to keep people prepared emotionally for wartime emergencies is to see that our peacetime house is in order. That is, there are no "psychiatric tricks or magic formulas" for dealing with the psychological aspects of national emergencies *if*, before the emergency, we as communities continue to ignore all the principles of mental health in the conduct of our churches, schools and social agencies; and if we close our eyes to the dangers of bigotry, prejudice and social tensions. Furthermore, those communities which are attempting to improve the quota of the daily satisfactions of their residents in peacetime will be better prepared to stand the shocks of war emergencies.

There can hardly be any argument with this thesis. It is, however, a bit ironic that the most destructive weapon man has ever produced is now supposed to scare us into being good peacetime citizens. Maybe some of us have been a little naive in the past.

As suggested above, only a confused world could produce such a confusing, but essentially valuable, guide as to how to prepare and maintain our emotions for an emergency which might never happen. The authors frankly state that the purpose of the report is to stimulate sound concern about the mental health implications of civilian defense, and encourage defense authorities to face some of the realities. In this sense, the report seems to this reviewer to be an excellent contribution. The questions raised are pertinent, and certainly should provide the focus for one aspect of local civilian defense planning. There are also excellent statements of principles on matters of mental health which are as valid in peace as in war.

It is clear from this report that nobody really knows how to prepare a people for a national emergency. And it may well be that psychiatrists and others in the mental health field are not necessarily any closer to some of the answers that the rest of us. To illustrate the point, it is a matter of record that in 1939 the leading mental health authorities in Great Britain predicted great increase in disorders and emotional neurotic diseases when the Germans started to bomb the English coast. These authorities believed that when conflict started there would be more mental than physical casualities. What actually happened, of course, demonstrated that the psychiatrists were mistaken and that they, too, as individuals, were caught in a mass of unknowns in 1939 just as many of our experts may be caught now.

As valuable as this report is—and it ought to be taken very seriously by our leaders in civilian defense, especially child welfare workers—by itself it may be too much for a great many people. It could create more anxieties than reassuring answers to frightening questions. The effect on some of the public could be not unlike the effect on parents of many child-care books. Some parents have now become so "educated" that they are incapable of figuring out when four-year-old Johnnie needs an ice cream cone.

Be that as it may—and again this reviewer would stress the basic excellence of this report—there is some comfort in the probability that the whole country is not going to take civilian defense quite as seriously as some of our leaders suggest. To do so might make living under civilian defense almost as bad as being attacked. To show, however, that the authors of this report are still with us, they assert that some public resistence to following blindly a program so little understood as civilian defense may actually be a sign of emotional health. Let us hope so.

HOWARD HUSH

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Dayton, Ohio

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Classified personnel ads are inserted at the rate of 10 cents per word; boxed ads at $7.50 per inch; minimum insertion, $2.50. Deadline for acceptance or cancellation is eighth of month prior to month of publication. Ads listing box numbers or otherwise not identifying the agency are accepted only when accompanied by statement that person presently holding the job knows that the ad is being placed.

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CASEWORKER, full professional training required; private, nonsectarian, CWLA member agency providing supervised foster home care, residential treatment for emotionally disturbed children; psychiatric consultation; student training; opportunity for professional development and advancement. Salary range $3600–$4860 according to experience. Retirement, Social Security. Write Clayton E. Nordstrom, Executive Director, Children's Foster Care Services, 4368 Lincoln Ave., Oakland 2, Cal.

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CASEWORKER - ADMINISTRATIVE ASSISTANT, professionally trained, for small institution serving normal children. Modern, cottage-type home with high standard of service and personnel practices. Beginning salary $3800 with apartment in administrative building. Write Fred R. Morris, Director, Children's Home, Claymont, Del.

CHILD WELFARE WORKERS for CWLA agency. Full professional training with experience substitution possible. Salary range $3216–$4392. Progressive personnel policies and expanding program; foster home placement, adoptions, relinquishment, counseling, protective services, etc. Fully qualified supervision and psychiatric consultation; psychological service. Write Personnel Officer, Denver Department of Welfare, 777 Cherokee St., Denver, Colo.

CASEWORKER, professionally trained. Unusually interesting foster care and adoption program. Good and consistent supervision. Salary range: $3400–$4400. Mrs. Irene Shapaker, Director, Children's Services, Inc., 46 E. Broad St., Savannah, Ga.

WANTED for private nonsectarian, child-placing agency. Supervisor, foster care program, Master's degree school social work plus experience in family or children's agency; $4900–$6300. Caseworkers, for adoption or foster care program; Master's degree school social work: $3420–$4920. Caseworker, carry direct treatment of emotionally disturbed children, with possibility of broader responsibilities if desired; Master's degree school social work plus training and experience in direct treatment of children: $3420–$5760. Excellent personnel practices for all positions; Social Security; appointment salaries dependent upon qualifications. Write Miss Lois Wildy, Executive Director, Illinois Children's Home and Aid Society, 1122 N. Dearborn St., Chicago 10, Ill.

CASEWORKERS. Immediate openings for professionally trained workers with private family and children's agency, giving family counseling, foster care and adoptive services. Qualified supervision, good psychiatric consultation and personnel practices. Minimum salary $3600. Starting salary dependent upon qualifications. Jessie B. Johnson, Executive Director, Family and Children's Service, 314—14th St., Denver, Colo., will be available for interviews at National Conference, Atlantic City.

CASEWORKER, professionally trained. Nonsectarian residential treatment center for emotionally disturbed children, part of total agency services to children that include foster home placement, adoption, etc. Supervision and psychiatric consultation available. Salary range $3200–$4700 dependent on experience. Good written personnel practices. Write to: Miss Ruth H. Atchley, Assistant Executive Director, Children's Services of Connecticut, 1680 Albany Ave., Hartford, Conn.

Supervisory Position to be open in July; to share with casework supervisor in supervision of staff and student training. Professional training and at least four years' successful experience as caseworker and beginning supervisory experience required. Salary $4000–$4800, depending on experience.

Caseworker for Adoption Department: Professional training and at least two years of successful casework experience required. Salary $3600–$4400, depending on experience.

Caseworker for General Caseload: Graduate of accredited school of social work, no experience necessary. Salary range $3200–$4400.

Private, nonsectarian agency offering foster home care, service to unmarried mothers, child guidance, and adoption. Clinic team provides direct treatment and consultation. Write for personnel policies and job classifications to Mrs. Jeanette H. Melton, New Hampshire Children's Aid Society, 170 Lowell St., Manchester, N. H.

CASEWORKERS (2) in multiple-service, state-wide agency—one in Hartford office to carry caseload of unmarried mothers and infants in temporary foster home care; one in Fairfield District (office located in Danbury) to carry family caseload. Requirements: Master's degree social work school; experience preferred but not required. Must drive car. Salary $3200–$4700. Appointment salary dependent on qualifications. Miss Verne Weed, Assistant Executive Director, Children's Services of Connecticut, 1680 Albany Ave., Hartford 5, Conn.

Caseworker

Child Welfare Worker with psychiatric background in a progressive child welfare agency offering residential and foster home care. Psychiatric consultation and treatment available. Salary $4200 – $4800. Temporary maintenance provided until satisfactory arrangements are made. Write Mrs. Verna Taylor, 3211 Taylor Ave., Racine, Wis.